Commonwealth of Virginia
Department of Medical Assistance Services
UNINSURED MEDICAL CATASTROPHE FUND
Application Form

Agency Use Only:
Date Signed Application Received:_____
Date Treatment Plan Received:_____
Date Eligibility Determined:_____
Date Treatment Plan Approved:_____
Cost of Treatment Plan:_____
Amount of Funds Available:_____
Date Provider Contract Signed:_____

INSTRUCTIONS:

1. Read the application carefully and follow all instructions given throughout the form.
2. Answer each question completely and accurately. Attach additional pages if needed.
3. Sign the application.
4. Return the original signed application to: Department of Medical Assistance Services
   Attn: Uninsured Medical Catastrophe Fund
   600 E. Broad Street, Suite 1300
   Richmond, Virginia 23219
5. Eligibility is determined on first come, first serve basis, based on the date the original signed application is received.

1. PERSONAL INFORMATION.

APPLICANT'S NAME (LAST NAME, FIRST NAME, MI)	HOME PHONE NUMBER ( )	WORK PHONE NUMBER ( )
RESIDENCE ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)		
MAILING ADDRESS IF DIFFERENT (INCLUDE CITY, STATE AND ZIP CODE)		

2. LIST EVERYONE LIVING IN YOUR HOME. List yourself on the first line, if you are married, list your spouse on the second line, and then list everyone else.

Name First MI Last	**Social Security Number**	**Citizenship** If No, List Alien #	**Date of Birth (MMDDYYYY)**	**This Person's Relationship to You**
Your Name		Yes ❒ No ❒ Alien #_____		
Spouse's Name, If Married		Yes ❒ No ❒ Alien #_____		
		Yes ❒ No ❒ Alien #_____		
		Yes ❒ No ❒ Alien #_____		
		Yes ❒ No ❒ Alien #_____		
		Yes ❒ No ❒ Alien #_____		
		Yes ❒ No ❒ Alien #_____		

3. INCOME. List **all family** income before taxes and other deductions. Send copies of all paycheck stubs for the previous month or if you do not have them, provide a letter from the employer verifying income. If self-employed, send a copy of the most recent Federal Tax Form 1040, Schedule C, or other proof of self-employment. Examples of income include but are not limited to:

- Wages/Self Employment
- Railroad Retirement Benefits
- Child Support/Alimony
- Interest/Dividends
- Social Security
- Veterans Benefits
- Rental Income
- Contributions
- Pensions/Retirement Benefits
- Trust/Annuity Payments
- Workers Compensation

Person Receiving Income	Type of Income	Employer or Source of Income	Gross Amount	How Often Received (weekly, biweekly, etc.)

3. INFORMATION ABOUT HEALTH INSURANCE.

Do you, your spouse or child, if applying for a minor, have health insurance? Yes ❒ No ❒

Are you or the person your are applying for, uninsured for the needed medical treatment? Yes ❒ No ❒

If you have insurance, why does it not cover the needed medical treatment? (Circle One Below)

Not in plan Maximum benefit reached Other(explain):_____

Policy Holder	Name of Insured	Health Insurance Company Name and Company Address	Insurance ID Number	Type of Coverage

4. INFORMATION ABOUT YOUR MEDICAL CONDITION.

Life Threatening Illness/Injury Diagnosis	Physician's Name, Address, Telephone Number

Applicant's Rights and Responsibilities:

I understand that:

- My application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political beliefs.
- I have the right to appeal an adverse determination regarding eligibility and the medical treatment plan. I understand that there will be no opportunity to appeal a denial of benefits because of a lack of funds.

I declare that all information I have given on this application is true and correct to the best of my knowledge and belief, including information about citizenship and alien status. I understand that if I give false information or withhold information I may be breaking the law and could be prosecuted for perjury, larceny or fraud.

My signature authorizes the Department of Medical Assistance Services to obtain any verifications necessary to establish and review my eligibility. I authorize the release of any medical or psychological information necessary to determine my eligibility to the Department of Medical Assistance Services.

Applicant Or Legal Representative Signature	Date

I completed this application for _____. I understand that if I aided or abetted this individual in obtaining assistance for which he/she is not eligible, that I may be breaking the law and could be prosecuted.

Signature:_____Relationship:_____Date_____

Address:_____Phone Number_____

UNINSURED MEDICAL CATASTROPHE FUND
Medical Treatment Plan (To be completed by the treating physician.)

Patient's Name	SSN	Life Threatening Illness/Injury

Medical Treatment Plan:

1. The Treatment Plan must be a course of treatment to remediate, cure, or ameliorate the life-threatening illness or injury.
2. The treatment must be in the future. No coverage is available for services already performed.
3. The course of treatment may not exceed 12 months.
4. The Treatment Plan must not be open-ended.
5. The Treatment Plan is to be completed by the certifying Physician.

Note: If the Treatment Plan is not submitted with the original signed application, it must be provided within the 45th day of receipt of the application or the application will be denied.

Describe in detail the treatment plan prescribed for the above referenced patient:

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I certify that _____, has the life threatening injury/illness stated above and submit the above medical treatment plan.

_____ _____ _____

Physician Name Physician Signature Date

Physician Address and Phone Number_____

Attach documentation of medical information for illness/injury for medical treatment plan evaluation.